R: 3/2007
MDE/OSE/EIS

UNIVERSITY/COLLEGE PROGRAM VERIFICATION

To ISD:_____, Supt.
_____
_____
_____

From:_____
University/College Code #:_____
Office of Special Ed. & Early Intervention Svcs.
Candidate Name:_____

Requested By: _____
School District: _____
Address: _____
_____
_____

This candidate is enrolled in the following training program:

- ☐ Emotional Impairment
- ☐ Learning Disabilities
- ☐ Cognitive Impairment
- ☐ Autism
- ☐ Hearing Impairment
- ☐ Early Childhood Special Education
- ☐ Physical Impairment & Other Health Impairment
- ☐ Physical Education for the Handicapped
- ☐ Visual Impairment
- ☐ Director
- ☐ Supervisor

This request applies to the school year 20_____ - 20_____.

For continuing temporary approval only:

I verify that the candidate has completed _____ semester hours toward full approval or endorsement between September 1 and August 31 of the previous school year.

If this candidate did not complete the required 6 semester hours for continuing approval, was additional coursework available? ☐ Yes ☐ No

Evaluator:_____ Date:_____